# SFHDiabHA10
# Help individuals with diabetes reduce cardiovascular risk

## Overview

This standard covers helping an individual with diabetes to reduce blood pressure and lipid levels in order to reduce cardiovascular risk. This may follow tests that show symptoms of diabetic complications, or it may be simply part of good practice in helping the person to manage their diabetes. The activities described in this standard may follow from the regular review of health and the agreement of an overall care plan.

Users of this standard will need to ensure that practice reflects up to date information and policies.

# SFHDiabHA10

Help individuals with diabetes reduce cardiovascular risk

## Performance criteria

*You must be able to:*

- P1 communicate with the individual and carer throughout as equal partners and encourage them to express their interests and concerns
- P2 assess the individual's and carer's understanding of
  - P2.1 current and previous care plans
  - P2.2 cardiovascular risk factors
  - P2.3 the significance of cardiovascular disease in the context of diabetes
  - P2.4 the benefits of reducing blood pressure and lipid levels
- P3 review the individual's history of managing blood pressure and lipid levels, and any difficulties they are experiencing with current therapies
- P4 help the individual and carer understand the choices and issues relating to monitoring and reducing cardiovascular risk factors
- P5 identify through discussion with the individual options for improving their blood pressure and lipid levels, taking into account the individual's
  - P5.1 age
  - P5.2 culture
  - P5.3 lifestyle choices
  - P5.4 family circumstances
- P6 help the individual and carer appreciate that hypertension and hyperlipidaemia are common in diabetes and that multiple drugs are often required in combination to achieve reductions in these risk factors
- P7 help the individual and carer understand that there is good evidence that these interventions are safe and effective and that, while targets can be difficult to achieve, any reduction in blood pressure and low density lipid cholesterol reduces cardiovascular risk and improves outcome
- P8 assess the need for referring the individual to other members of the care team for help or advice, and where this is appropriate discuss and agree the referral with the individual
- P9 agree individualised targets, plans and timescales for achieving improved blood pressure and lipid levels, including the number of appointments that will be needed
- P10 agree methods of monitoring progress towards these goals
- P11 in partnership with the individual, jointly plan lifestyle measures to reduce their cardiovascular risk
- P12 provide or arrange for the provision of any new medications required by the plan, and ensure the individual understands how to use them
- P13 help the individual and carer understand how to use the new medication alongside any other current medication
- P14 clarify what the individual will do in the event of side effects of the medication, and who they will contact
- P15 identify and discuss the support network available to the individual and
  - P15.1 ensure they have clear contact details

P15.2 refer them to other sources of support where this has been agreed

P16 provide copies of the agreed plans for the individual and carer, for their records

P17 record the targets and strategies you have agreed in a form that can be followed by other members of the care team, the individual and carer

P18 identify in partnership with the individual and carer progress with the strategy, including achievements, learning, awareness, shortfalls and difficulties

P19 encourage and reinforce the individual's achievements, and provide positive support where they have encountered difficulties

P20 consider options for modifying the plan when it is not meeting the individual's needs, based on

P20.1 progress to date

P20.2 changes in the individual's condition

P20.3 changes in the individual's circumstances

P21 negotiate changes to targets and plans, based on experience to date, to achieve a balance where necessary between

P21.1 the individual's lifestyle choices

P21.2 progress towards blood pressure and lipid target

P22 provide copies of the revised plan for the individual and carer, for their records

P23 record the outcomes of the review in a form that can be followed by other members of the care team, the individual and the carer

# SFHDiabHA10

Help individuals with diabetes reduce cardiovascular risk

## Knowledge and understanding

*You need to know and understand:*

K1 the NSFs for diabetes, cardiovascular disease and renal disease
K2 NICE guidelines on diabetes monitoring, management and education, and on cardiovascular disease
K3 causes of diabetes
K4 signs and symptoms of diabetes
K5 normal and abnormal blood glucose and HbA1c values
K6 how to monitor glucose levels, HbA1c, blood pressure
K7 typical progressive patterns of diabetes
K8 the importance and effects of patient education and self management
K9 the psychological impact of diabetes, at diagnosis and in the long term
K10 how to gather information from patients about their health
K11 how to work in partnership with patients and carers
K12 the social, cultural and economic background of the patient/carer group
K13 the impact of nutrition and physical exercise on glycaemic control
K14 the effects of smoking, alcohol and illicit drugs
K15 the effects of, and how to manage, intercurrent illness
K16 how to manage hypoglycaemia
K17 the medications used to manage diabetes
K18 methods of managing multiple medications
K19 the interactions between cardiovascular risk factors
K20 the long term complications of diabetes and when they are likely to occur
K21 how to examine feet and assess risk status
K22 how to monitor cardiovascular risk
K23 how to monitor for renal disease
K24 how to monitor for diabetic retinopathy
K25 the law and good practice guidelines on consent
K26 the staff member's role in the healthcare team and the role of others
K27 local guidelines on diabetes healthcare
K28 local referral pathways
K29 local systems for recording patient information
K30 quality assurance systems
K31 the process of notification for legal and insurance purposes
K32 sources of practitioner and patient information on diabetes
K33 contact details of local and national support groups
K34 how individuals can access local facilities for exercise and physical activity, education and community activities

# SFHDiabHA10

Help individuals with diabetes reduce cardiovascular risk

## Additional Information

### External Links

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: HWB6 Assessment and treatment planning

# SFHDiabHA10

Help individuals with diabetes reduce cardiovascular risk

| | |
|---|---|
| **Developed by** | Skills for Health |
| **Version number** | 1 |
| **Date approved** | June 2010 |
| **Indicative review date** | June 2012 |
| **Validity** | Current |
| **Status** | Original |
| **Originating organisation** | Skills for Health |
| **Original URN** | Diab HA10 |
| **Relevant occupations** | Health, Public Services and Care; Health Professionals; Healthcare and Related Personal Services |
| **Suite** | Diabetes |
| **Key words** | diabetes |